BEHAVIORAL / PHYSICAL HEALTH COORDINATION

State Form 51856 (R / 9-04) / OMPP 0016

Family & Social Services Administration
Office of Medicaid Policy & Planning

IMPORTANT (PLEASE READ): This form may contain protected health information from the INDIANA HEALTH COVERAGE PROGRAMS (IHCP), which is intended only for the use of the individual or entity named in this form. Any unintended recipient is hereby notified that the information is privileged and confidential, and any use, disclosure or reproduction of this information is prohibited. Any unintended recipient should contact the sender immediately.

Insurer patient identification number		Date (*month, day, year*)	
Name of member		Date of birth (*month, day, year*)	
Health care provider		Behavioral health provider	
Address (*number and street*)		Address (*number and street*)	
City, state, ZIP code		City, state, ZIP code	
Telephone number ( )	Fax number ( )	Telephone number ( )	Fax number ( )

This form was filled out by

The sharing of prescribed medication and treatment recommendations between this patient's physical healthcare provider and behavioral healthcare provider are essential for safe, effective coordination of care. Please complete the applicable section of this form and forward to the appropriate health care professional.

More information: www.indianamedicaid.com

PATIENT CONSENT

Please check if you DO NOT want the following protected health information released: ☐ **Behavioral Health** ☐ **Substance Abuse** ☐ **HIV/AIDS**

This authorization will expire on _____ (Date (*month, day, year*)). I authorize the use and/or disclosure of my protected health information as described above. I understand this authorization for release of protected health information is made to confirm my wishes. I understand that I may revoke this authorization at any time by giving written notice to the person or organization that is authorized above to release information. My health care provided by _____ (Name of provider) will not be affected if I do not sign this form. This information disclosed by this release may be re-disclosed by the recipient and may no longer be protected.

Signature of member

Signature of member

☐ **Member declined to participate**

PHYSICAL HEALTH CARE PROFESSIONAL TO COMPLETE THE FOLLOWING

☐ **Medication log attached**

MEDICATION	DATE STARTED	PRESCRIBED DOSAGE	Allergies to medications:
1.			
2.			Current diagnosis:
3.			
4.			Comments:
5.			
6.			

BEHAVIORAL HEALTH PROVIDER TO COMPLETE THE FOLLOWING

☐ **Medication log attached**

MEDICATION	DATE STARTED	PRESCRIBED DOSAGE	Allergies to medications:
1.			
2.			Current diagnosis:
3.			
4.			Comments:
5.			
6.			

Please provide the following information regarding (*Member name*)	2. Is another appointment required? ☐ Yes ☐ No	If yes, date and time scheduled	☐ AM ☐ PM
1. Results of appointment, including any prescriptions ordered (*attach forms as necessary*)	3. Are there any special instructions for this member to follow? (*please describe*)		